CHAPTER FOUR
HEALTH CARE POLICY

1. Creating a State Health Insurance Exchange

Recommendations

1. The state health care exchange should be transparent.
2. The exchange should be easy to use and should achieve lower health care costs.
3. The exchange should be nonpolitical, and pricing and benefit levels should be set by the private insurance market, not the government.

Background

In March 2010, President Obama signed the Patient Protection and Affordable Care Act, called simply the Affordable Care Act or, ACA. Under the ACA the federal government will manage the health care of all Washington state residents. Passed with narrow partisan majorities, the law remains unpopular with the public and may be repealed. In the meantime, the following sections describe the main steps the state must take to comply with the law.

One half of the $1 trillion cost of the legislation will be spent on taxpayer-funded subsidies to purchase health insurance in new state health insurance exchanges. Eligibility for the subsidy will be based on an income of 133% to 400% of the federal poverty level. For a family of four, 400% of the poverty level is currently $89,000, which will increase to $96,000 by 2016. Subsidies will thus go to upper middle class people as well as the poor.

State exchanges must offer four levels of benefit plans plus a high-deductible, catastrophic plan for young adults. This forces each state to either set up its own exchange or participate in a regional, multi-state program. If a state does not comply, the federal government will force that state's residents into a federal program.

An estimated 100 million people will be eligible for subsidies in an exchange. An additional 40 million people may be forced into the exchanges after their employers drop employee health insurance because of high costs. This could represent up to 800,000 people in Washington state.[1] These additional people will put a considerably bigger burden on taxpayers than the administration's original cost estimate of $1 trillion.

In 2011, the Washington legislature passed legislation to create a state exchange, one of the first states to do so. An eight-member voting board and a nonvoting chairperson, all appointed by the governor, will make the decisions in the exchange. These decisions must comply with federal regulations.

Policy Analysis

In designing the exchange, Washington could start with a "clean slate" and move toward a patient-oriented, consumer-driven system. The exchange can be a transparent, information-based market where individuals and small groups select plans that fit their needs. States can use the exchange as a mechanism to combine all existing state government insurance plans, such as Medicaid and Basic Health, into one administrative program.

Done right, the exchange should be easy to use and should promote decreased health care costs. Insurance rates and benefit levels should be set by the insurance market and not by government regulations. The administration of the exchange should be done through a nonpolitical, independent board, not by a politicized bureaucracy.

Under the federal legislation, "essential benefit" plans must meet federal requirements, but the state exchanges should also offer an array of "mandate-free" or "mandate-light" insurance plans that satisfy market needs. Any subsidies in the exchange should flow to and be controlled by the patient, not by insurance executives or government officials. Tax credits or deductions to purchase health insurance could also be offered in an exchange.

So far two states, Utah and Massachusetts, are operating functioning exchanges. Utah has an information-based clearinghouse that serves as an electronic insurance broker. Overhead costs are low,

consumers have wide choices and enrollment is growing in this new exchange. Utah's approach is clearly popular with state residents.

Massachusetts took a different approach. Starting in 2006, it created a much more restrictive, top-down exchange. The uninsured rate in the state dropped from 10 to three percent, which greatly increased demand for health care, and not enough doctors were available. Consequently, access to health care in Massachusetts has dramatically decreased and costs to state taxpayers have exploded.

Each state can function as a laboratory to design the most efficient, cost-effective exchange. Although the new federal health care legislation includes hundreds of new mandates and regulations, states like Washington have an opportunity to overhaul their existing programs, start fresh and establish a meaningful patient-directed health care system.

The alternative is to submit to more government regulation and central planning with the attendant bureaucratic inefficiencies, which will not increase access or decrease costs to patients.

Recommendations

1. **The state health care exchange should be transparent.** The health care exchange should provide citizens with accurate, neutral information about their health care choices. It should present private insurance and state-run programs on an equal basis, allowing individuals and families, not government managers, to choose plans that best fit their needs.

2. **The exchange should be easy to use and should achieve lower health care costs.** The primary goal of the exchange should be to increase consumer choice and reduce costs through open competition. Premium rates and benefit levels should be set by the market, not by state regulators.

3. **The exchange should be nonpolitical, and pricing and benefit levels should be set by the private insurance market, not the government.** The exchange should be administered by an independent board, insulated from political influence. Citizens should be allowed the widest possible choice, from inexpensive low-mandate plans to high-priced "Cadillac" coverage. Any tax subsidy or entitlement should be controlled by individual citizens, not dictated by state bureaucrats.

2. The Affordable Care Act and Medicaid Expansion

Recommendations

1. Allow Health Savings Accounts (HSAs)
2. Aggressively pursue fraud in the Medicaid program.
3. Tighten eligibility requirements.
4. Encourage the use of block grants.
5. Repeal the Affordable Care Act (ACA).

Background

The ACA expands Medicaid to include any adult earning less than 133% of the federal poverty level. Estimates reveal that 16 to 23 million new patients nationally and 280,000 to 360,000 people in Washington state will be added to Medicaid.[2]

At the current rate of spending increases, Medicaid spending will nearly double, compared to fiscal 2010 levels in ten years, that is, by fiscal 2020.[3] At an average growth rate of seven percent per year, Medicaid is the fastest-growing federal entitlement program.[4] The millions of new enrollees who will be added to create a "new" Medicaid program under the ACA law will make this cost problem much worse.

Obviously Medicaid is financially unsustainable and changes will be needed to avoid the program's financial collapse. Some Medicaid reform proposals, such as negotiating discounts, shifting patients away from emergency rooms, and controlling drug costs, do not address the underlying problem of funding a broad health care entitlement.[5]

On the other hand, proven policies like health savings accounts (HSAs), aggressively pursuing fraud aggressively, tightening eligibility requirements, and using block grants to states, have been shown to be effective in controlling costs in both the health care and welfare policy areas.

To help provide state officials with the necessary flexibility, Medicaid should be restructured as an indexed block grant program. An indexed block grant would allow state Medicaid funds to grow each year based on a national fiscal growth factor.

An indexed Medicaid block grant would also provide Washington state the flexibility to set up one state-controlled health insurance program to cover all patients now covered by Medicaid, Basic Health and the Children's Health Insurance Program.

Rather than compounding the existing Medicaid problems, the new federal health care law should be repealed. There is no logical reason to enlarge an entitlement program that is already going bankrupt.

Policy Analysis

The current Medicaid program is arguably the worst health insurance plan in the country. Patients have little incentive to limit their use of health services, further driving up costs. The tragic irony is that because of low provider reimbursements, access for patients is severely limited. The number of doctors who are not seeing new Medicaid patients grows larger each year. On paper, all Medicaid patients have insurance, but that does not mean they are able to see a doctor.

After more than 40 years, there is no evidence Medicaid has improved health outcomes for the vast majority of either children or adults enrolled in the program.[6] Medicaid, like any entitlement that offers services apparently for free, has encouraged overutilization of health care resources. When services appear to be "free," the health care market has no ability to place a true value on that service and no way to know if limited resources are being allocated efficiently.

Limited public safety net programs will always be needed to provide health care for the poorest and most vulnerable people in our society. However, the bloated and expanding Medicaid entitlement program, as it is presently structured, is not sustainable.

A better plan is to repeal the ACA law and stop the new, expanded Medicaid program before it starts. The government should then focus on meaningful reform to the current Medicaid, like adopting block

grants, based on changes that have proven successful in other entitlement programs. This would ensure that Medicaid is placed on a sound financial basis so it remains reliable enough to provide dependable health services for low-income families.

Recommendations

1. **Allow Health Savings Accounts (HSAs).** Allowing HSAs would let people on Medicaid control their own health care dollars and spending. HSAs have been shown to decrease costs of health care in the private market. They should be available in the Medicaid program as well.

2. **Aggressively pursue fraud in the Medicaid program.** Estimates put fraudulent abuse in government health care programs as high as 30%. The state should do everything possible to eliminate fraud.

3. **Tighten eligibility requirements.** Restoring the definition of Medicaid eligibility to the original 133% of the federal poverty level would relieve financial pressure on the program. A more focused eligibility standard would ensure that Medicaid serves as a health care safety net for the poor.

4. **Encourage the use of block grants.** Block grants would lead to more state control and fewer federal regulations. States are in a better position to determine the health care needs of their poor citizens. The federal government should give the states a bigger role in regulating their individual Medicaid programs.

5. **Repeal the Patient Protection and Affordable Care Act.** Almost one half of the spending in the ACA will go to the expansion of Medicaid. Medicaid is already financially insolvent and limits access to health care for current enrollees. Expanding an ineffective program makes no sense.

3. Guaranteed Issue and Community Rating

Recommendations

1. Avoid imposing price controls on insurance policies.

2. Repeal the Affordable Care Act (ACA) to free states from guaranteed issues and community rating.

Background

The ACA forces insurance companies to price policies based on community rating limits and to accept anyone as a customer (guaranteed issue) regardless of pre-existing conditions. Washington state has already had experience with community rating and guaranteed issue.

In 1993, Washington had approximately 600,000 uninsured residents, or about 11% of the population. That year Olympia passed sweeping health care reform legislation, the Washington State Health Plan, in an effort to reduce the number of uninsured and make health coverage more affordable.[7]

The basis of the program was to require all state residents not in Medicare to join a managed competition plan. The goal of the program was to provide universal coverage for all Washington residents. The program included:

1. Price controls on insurance premiums.
2. Statewide community rating.
3. New mandates on employers and individuals.
4. A guaranteed issue rule.

The plan created a powerful new state bureaucracy, raised taxes, added restrictions on employers and individuals, and gave state government vastly expanded control over health care.

The consequences of the plan were devastating. In the following years, 14 health insurance companies left the state, and the few remaining insurers were forced to raise prices by up to 40%. The number of

uninsured rose 20%, as people were forced to drop policies they could no longer afford. The state began attracting sick patients from all over the country because of the guaranteed issue provision.

Policy Analysis

The guaranteed issue and community rating requirements were the primary reasons the 1993 law failed.

The guaranteed issue law forced insurers to sell a policy to anyone, regardless of medical risk or pre-existing conditions. One insurance company received a polite letter from a satisfied policyholder. She had purchased a policy during her recent pregnancy and, now that her baby was born, she no longer needed the policy and was dropping her coverage. She assured the company she would certainly choose them again when she needed to pay for medical care in the future.[8]

The community rating law required premiums charged by an insurance company to be an average of all premiums (for sick and healthy, young and old, etc.) in a given region. Exceptions were allowed for some factors, such as age, but the rating "bands" (legal controls on the price of insurance policies) kept insurers from setting prices to reflect the real risk involved in selling someone a particular insurance policy.

Together, community rating and guaranteed issue rules created two bad effects. First, they encouraged healthy people not to buy health insurance, since state rules made the price artificially high. Second, they encouraged people to wait until they got sick before buying insurance.

By 1994, it was obvious the plan was not working and a citizen revolt occurred at the voting booths. The Democrats in the legislature lost their majority, and the Democratic governor who supported the plan was forced to approve its repeal.[9]

While most elements of the 1993 reform plan were repealed, Washington's health insurance market never fully recovered. The guaranteed issue law, though modified, remains in place, the market is burdened by more than 58 state-imposed mandates, and the state levies a special tax on all insurance policies.

When passed, supporters said the Washington Health Plan would provide universal coverage and lower health care costs, but the plan failed in both respects. The legacy of the Washington Health Plan is an insurance market burdened by costly regulations, a small number of remaining insurance companies, a high number of mandates, the guaranteed issue law and community rating price controls. Today, health costs are higher than ever, and the uninsured rate is no better than when the plan was proposed seventeen years ago.

Recommendations

1. **Avoid imposing price controls on insurance policies.** Insurance risks and policy pricing should be set by the insurance companies. History has shown that when the government dictates guaranteed issue and community rating mandates for the insurance companies, competition is eliminated and patient choice in the health insurance market decreases.

2. **Repeal the Affordable Care Act (ACA) to free states from guaranteed issues and community rating.** Guaranteed issue and community rating are fundamental to the national ACA law. States will not be free of the harmful effects of these two policies as long as ACA remains in place.

4. Health Care Mandates

Recommendations

1. Authorize low-cost, mandate-free health insurance.
2. Require an independent cost-benefit analysis of existing health care mandates.
3. Adopt a moratorium on new health care mandates.
4. Urge Congress to allow the interstate purchase of health insurance so Washington residents can shop for health coverage in any state.

Background

Paying for health care coverage is one of the fastest-rising costs facing businesses and citizens in Washington. At the same time, health insurance is one of the most heavily regulated sectors of our state's economy. These two trends are linked, with increasing state regulation playing a major role in driving up the cost and reducing the accessibility of health care coverage.

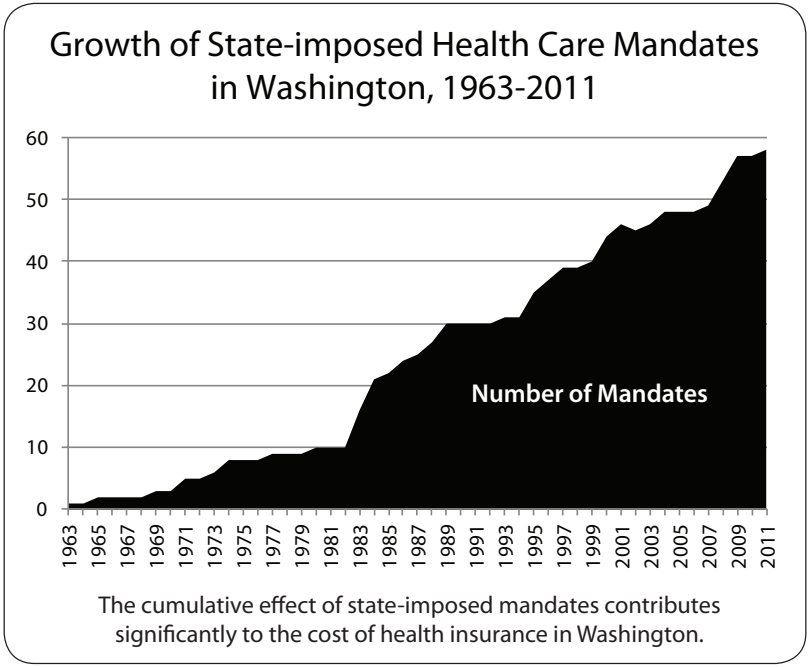
In 2009, national health care spending grew four percent to an estimated $2.5 trillion, or $8,086 per person.[10] Health care spending now makes up about 17.6% of the national economy and is projected to increase by an annual average of 6.3% over the next decade, to nearly 20% of GDP by 2019.[11] In 2010, health insurance premiums continued to rise for employers and workers, marking a 138% increase in the cost of premiums since 1999.[12]

A major driver of health care costs is the impact of state-imposed mandates. Mandates are state laws listing benefits for specific conditions or services that every health insurance policy sold in the state must cover, whether insurance purchasers have requested the coverage or not. Mandates increase the cost of basic health coverage by about 20 to 50% overall, depending on the state, or by about 0.5 to 1.0% per mandate.[13] This is part of a national problem. There are 2,156 health care mandates nationwide.[14]

State-imposed mandates interfere with the normal voluntary relationship between buyers and sellers. Mandates mean insurance purchasers are forced to pay for medical coverage they may not otherwise choose, and patients are made to bear the cost of services they do not want and may never use. This creates a "crowding out" effect, by which some health care services are not available because insurers must offer the benefits mandated by the state instead.

Moreover, mandates may encourage health providers to follow fixed clinical procedures and services, depriving doctors of the discretion they need to practice medicine. By doing so, they increase the likelihood that medical resources are misallocated, and that care provided through existing health care insurance plans is not flexible, innovative or efficient.

Beginning with a single access-to-provider mandate in 1963 (for chiropody), the number of new mandates and enacted changes to existing mandates in Washington has grown to 58 in 2011.[15] During two distinct periods the number of new mandates surged. Between 1982 and 1990 the number of mandates tripled, from 10 to 30, and from 1993 to 2001 their number increased a further 50%.[16] Since 2001, lawmakers have imposed 10 additional mandates. The yearly increase in the number of health care mandates is shown in the following chart.



Such an extensive set of state-imposed restrictions on what consumers can buy would have a substantial impact on any industry. It is not surprising, then, that these mandates have considerable impact on health insurance prices and availability in Washington.

Research by the Congressional Budget Office (CBO) found that "government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums." CBO cited "mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births" as examples of such high-cost insurance regulations.[17]

Mandates and their associated costs contribute to the number of uninsured people in Washington. As mandates increase, the number of uninsured people increases as well. According to the state Insurance Commissioner, over a million Washingtonians, 14.6% of the state's population, will be without health insurance by the end of 2011.[18] Among working-age adults (ages 19 to 64), one in five people will be without health coverage.[19]

The authors of one national study found that state-imposed mandates may account for as many as one in four Americans who are uninsured. "Mandates are not free," they report, "they are paid for by workers and their dependents, who receive lower wages or lose coverage altogether."[20]

Another study found a strong correlation between higher health coverage costs and increases in the uninsured population. Professors Frank A. Sloan and Christopher J. Conover, of Duke University, found that "the higher the number of coverage requirements placed on plans, the higher the probability that an individual was uninsured, and the lower the probability of people having any private coverage, including group coverage. The probability that an adult was uninsured rose significantly with each mandate present."[21]

Policy Analysis

The number of mandates and other state imposed regulations means that basic health insurance is not available in Washington. State law contains a "value" or "bare-bones" insurance provision dating from

1990, but it includes many detailed regulatory requirements and is not free of all mandates.[22]

A policy allowing true basic health insurance free of state-imposed mandates has the following advantages:

- Promotes the public interest—the public benefits when government policies allow greater, rather than fewer, choices in the health care market.
- Encourages personal freedom—citizens would have greater say in one of the most personal and sensitive areas of life.
- Enhances market efficiency—health care consumers would be able to seek the coverage they need at a price they are willing to pay.
- Reduces the number of uninsured—individuals, families and small business owners who are currently priced out of the market would have new opportunities to gain access to health insurance.

Letting Washingtonians Buy Health Coverage in Any State

Right now state law makes it illegal for people in Washington to buy health insurance in another state, no matter how good a deal that policy might be for them. This prohibition generally does not apply to other types of insurance, like auto, homeowners and life insurance.

Today the innovative and fast-moving internet makes access to choice, price competition and product information easier than ever. Dozens of easy-to-use websites provide health coverage information. One site alone (eHealthInsurance) lists at least 147 plans.

Other insurance models work this way. Multi-state companies selling auto, homeowners and life insurance offer choice, good prices and quality service for one reason only. The consumer is in charge, and insurers know they have to please the customer, not government regulators or company benefits managers, in order to get business.

Greater market choice and better prices in health care are available across the country and easily available through the internet.

Washington lawmakers should remove the legal barriers and let their citizens tap into a nationwide market in affordable health care.

Recommendations

1. **Authorize low-cost, mandate-free health insurance.** Insurance should be available to individuals and businesses without state-imposed mandates, with pricing that reflects its actual value to consumers.

2. **Require an independent cost-benefit analysis of existing health care mandates.** An independent cost-benefit analysis would more accurately determine the role of mandates in increasing the cost of health coverage.

3. **Adopt a moratorium on new health care mandates.** A moratorium on new mandates would create a much-needed "time-out" in the growth and complexity of health insurance regulations. Policymakers would then have the opportunity to learn about the long-term impact of mandates on the price and availability of health care coverage.

4. **Urge Congress to allow the interstate purchase of health insurance so Washington residents can shop for health coverage in any state.** The number of mandates varies widely from state to state. By gaining access to a national market in health coverage, Washington residents could shop for options that decrease costs and increase choice in the marketplace.

5. Medical Liability Reform

Recommendations

1. Cap the amount of noneconomic damages that can be awarded by a jury at no more than $350,000.

2. Eliminate joint and several liability rules.

3. Encourage more far-reaching medical liability reforms such as schedules of damages, "early offer" programs and specialized medical courts.

4. Strengthen the effectiveness of the Medical Quality Assurance Commission.

Background

Currently, individuals may file civil lawsuits against doctors, clinics and hospitals for unlimited amounts of money for breaches of duty that cause injury. This legal system has two primary purposes—deter doctors from acting negligently and compensate injured people for the losses they have suffered.

Nationwide, medical malpractice lawsuits are common.[23] Sixty-one percent of physicians age 55 and older have been sued at some point during their careers. Nine out of 10 surgeons age 55 and older have been sued.[24]

Although not required by state law, most doctors in Washington buy malpractice insurance to protect themselves and their practices against expensive jury verdicts.[25] The high cost of malpractice insurance contributes to the rising cost of health care, and it is having a harmful effect on doctors, patients and payers.

Over the years, the average jury verdict in Washington has increased by almost 70% and the average settlement cost has increased by over 50%. Similarly, the number of verdicts and settlements over $1 million increased tenfold in roughly a decade. High jury awards are not

isolated events—they influence future court cases as well as out-of-court settlements.

Higher claim costs are the primary reason for increased malpractice insurance premiums. Because of Washington's joint and several liability rule, each defendant in a medical malpractice lawsuit is potentially responsible for paying the total jury award, regardless of how small that defendant's role was in causing a patient's injury.

This rule encourages injured patients and their lawyers to seek full payment from the defendant with the "deepest pockets," not necessarily the one most responsible for causing harm.

Malpractice lawsuits affect physician behavior, contributing to defensive medicine and driving up health care costs. Defensive medicine refers to a doctor ordering diagnostic tests, procedures or prescription drugs mainly to reduce malpractice liability, not to serve the patient better. In a recent Gallup survey, physicians claimed more than 20% of their practice to be defensive in nature, completely unnecessary for the health of their patients.[26]

A recent study found that medical liability costs and defensive medicine account for at least 10% of medical care costs.[27] The exact figure is uncertain, but estimated annual costs range from $60 to $200 billion.[28] Physicians in a state with high malpractice costs, like Washington, are more likely to retire early, leave the state, or reduce their scope of practice. Fewer doctors restricts patients' access to quality health care.

In 2005, two contentious medical malpractice initiatives, Initiatives 330 and Initiative 336, appeared on the November ballot. Each took a radically different approach to changing Washington's medical liability laws. Both initiatives failed, prompting the governor to negotiate, and the legislature to pass, a health care liability bill in 2006.

The law made modest changes to patient safety, liability insurance and the legal process. Most of these changes, however, were minimal and have not resolved the medical malpractice crisis in Washington. Furthermore, since its passage, the reform has been severely curtailed by the Washington Supreme Court, which struck two primary sections of the law in 2009 and 2010.[29]

Policy Analysis

The majority of states have adopted some form of limitation on jury awards, primarily on noneconomic damages. Many states model their tort reform on California's Medical Injury Compensation Reform Act (MICRA), enacted in 1975. MICRA caps noneconomic damages at $250,000 and limits attorneys' fees based on a sliding scale.

Under MICRA, malpractice claims in California are settled in one-third less time than the national average of more than five years, and malpractice insurance rates have dropped by 40% since MICRA's inception. The result is a system that better serves the needs of patients by reducing the cost of litigation and speeding compensation payments.

Noneconomic damage caps reduce the average size of an award and limit malpractice insurance premium growth. Caps have been demonstrated to result in a 23 to 31% reduction in the amount of an average jury award. Moreover, states with caps of $350,000 or less on non-economic damages saw increases in malpractice insurance premiums of 13% in 2000–01, while states without caps experienced a 44% increase in premiums.

In 2003, Texas capped malpractice jury awards for noneconomic damages at $250,000. As a result of this and other reforms, the state's largest malpractice insurance company cut its premiums by 35%, resulting in $217 million in savings to doctors, and their patients, over a four-year period.[30]

Officials at one nonprofit hospital, Christus Health, report malpractice reform has saved them some $100 million, which they can now devote to charity care, instead of fighting lawsuits. Limiting jury awards has made Texas a much more attractive place to practice medicine. In the years following passage of malpractice reform, thousands of doctors entered the state, many to serve in rural areas.

Joint and Several Liability

As with malpractice reform, the majority of states have reformed their joint and several liability laws. In states that abolished joint and several liability, physicians are not held liable for the negligent acts of other doctors. This approach is fairer because it allocates financial

damages in proportion to each defendant's actual level of fault. It also reduces costs because malpractice insurers, when issuing policies, know how much risk each doctor is assuming.

Washington needs reforms similar to those in other states that are successfully reducing costs while protecting patients. Practical reforms include reasonable limits on noneconomic damages and eliminating joint and several liability. These recommended reforms represent an important start.

More Comprehensive Medical Liability Reform

The medical liability system is complicated, and it currently does not adequately meet its two objectives of deterring medical negligence and compensating injured patients.

Policymakers should consider broader, long-term reforms that fully address the fundamental problems with the medical liability system. Effective long-term reforms include:

- A regular schedule for determining noneconomic damages, with financial awards increasing with the seriousness of the patient's injury.
- "Early offer" programs that allow fast payment of compensation with an injured patient's agreement not to seek further payments;.
- Specialized medical courts where independent medical experts can make faster, more consistent decisions about awarding just compensation to injured patients.

Improving the Medical Quality Assurance Commission

The purpose of the medical liability system is to secure fair compensation for injured patients, punish negligent or incompetent doctors, and deter future acts of negligence. The court system by itself, however, is ill-equipped to police the medical profession and ensure the good conduct of doctors. The enforcement powers of the executive branch are best suited for that.

Washington regulates physicians through the Medical Quality Assurance Commission (MQAC). The Commission is responsible for establishing, monitoring and enforcing qualifications for licensure, consistent standards of practice and continuing competency.

While patient complaints and out-of-court malpractice settlements may not be widely known to the public, they are no secret to the members of MQAC. Acting on this information, the state should investigate, impose limits on practice and, if need be, revoke the licenses of negligent doctors *before* they do serious and lasting harm to patients.

There must be a system in place to protect those physicians testifying against incompetent doctors from legal retribution. Competency should be decided by the MQAC, not the courts.

Recommendations

1. **Cap the amount of noneconomic damages that can be awarded by a jury to $350,000 or less.** As in other states, the goal is to make future awards more predictable, which in turn will make insurance premiums more predictable.

2. **Eliminate joint and several liability.** Doctors should be held responsible only for their own decisions and actions, not the decisions and actions of others. This will decrease the need for patients to bring a marginal suit against a "deep pockets" defendant.

3. **Encourage the development of reforms such as schedules of damages, "early offer" programs and specialized medical courts.** Long-term solutions need to be developed if the goals of the medical liability system are to be achieved.

4. **Strengthen the effectiveness of the Medical Quality Assurance Commission.** Physician competency and quality are regulated by state law. Regulators need to make greater efforts to assure the public that the few bad doctors in the medical profession are identified and removed from practice.

6. Medicaid Reform

Recommendations

1. Adopt a state voucher program to give Medicaid recipients control over their health care dollars.

2. Encourage Congress to allow block grants of federal funds instead of matching funds to the states.

Background

The Medicaid program, created in 1965, provides federal and state funding on a matching basis for health care for the poor and disabled. Today, over 60 million people receive services through the Medicaid program.[31]

There are currently four groups of people receiving assistance through the Medicaid program. These are the poor, the disabled, mothers and children, and individuals needing long-term care. Although mothers and children make up most of the beneficiaries, long-term care accounts for 70% of yearly Medicaid dollars.[32]

Physician participation in Medicaid is voluntary. Medicaid payments to doctors have always been lower than those of any other insurance carrier, including Medicare. Consequently, physicians commonly lose money with every Medicaid patient they treat and doctors have been withdrawing from the program, thus decreasing access to health care for low-income and disabled people.

In 1966, the cost of Medicaid was $1 billion. Medicaid costs exploded to $330 billion by 2007.[33] It is estimated that the cost will rise to $900 billion a year by 2019. In many years, the financial burden of Medicaid grows at twice or three times the rate of inflation. At its present rate of growth, by 2030 Medicaid-funded nursing home expenditures alone will equal the size of the entire Social Security program today.

Policy Analysis

Medicaid has resulted in a number of harmful effects for the very people it is intended to help. First, it discourages work and job improvement for low-paid employees, since with increasing income, workers lose their Medicaid benefits.

Second, Medicaid encourages employers of low-income workers not to offer health benefits. They assume, or hope, taxpayers will provide these benefits instead.

Third, Medicaid discourages private insurance companies from offering nursing home policies. As the government program crowds out private carriers, this insurance market gets smaller every year, resulting in less choice for consumers.

Lastly, Medicaid discourages charity care and philanthropic giving in the health care sector. If the government is assumed to be already giving health care to low-income people, private donors shift their money to other causes.

State lawmakers are caught in a vicious cycle wherein the more of their citizens' state tax money they devote to Medicaid, the more money they receive from the federal government. If Washington state spends a dollar on Medicaid, it gets another dollar in matching funds from federal taxpayers, seemingly doubling the state's spending on health care.

The federal match makes state lawmakers feel they are receiving "free" money, so it is no surprise that Medicaid is the largest budget item for virtually every state in the country. Of course the "free" matching money is provided by federal taxpayers, who are the same people as state taxpayers.

In 1996, the federal government reformed welfare and repealed the Aid to Families with Dependant Children (AFDC) program. The AFDC operated with state and federal matching funds, like Medicaid. Opponents of AFDC repeal predicted tragedy for low-income families. That didn't happen. In fact, welfare caseloads decreased dramatically and poverty across all demographic groups declined as well, as more families became economically independent and entered the workforce.

The basis for the success of AFDC reform included a five-year lifetime limit on participation and the freezing of federal funds, which were then distributed to the states as block grants.

Policymakers can learn from the welfare reform of 1996. Federal funding for Medicaid should be given as block grants, not as matching funds. This would induce states to budget for the truly needy and not rely on a blank check from federal taxpayers.

To introduce the responsible use of Medicaid funds, recipients should be given individual vouchers so they can control their own health care spending. These vouchers could be used to purchase private insurance policies and could be used to fund personal Health Savings Accounts. Dollars not spent could be rolled over from year to year and could be taken from one job to another.

Like welfare reform, this change in the Medicaid program would help lift poor families out of poverty, by making them independent and allowing them to own their health care coverage.

Recommendations

1. **Adopt a state voucher program to give Medicaid recipients control over their health care dollars.** Vouchers would allow Medicaid recipients to choose the health insurance policies that work best for them, and to participate in consumer-driven health care. It would also increase access by giving Medicaid recipients a broader choice of doctors.

2. **Encourage Congress to allow block grants of federal funds instead of matching funds to the states.** Medicaid costs will continue to spiral out of control unless a meaningful ceiling is placed on spending. A simple method to accomplish this is to use federal block grants instead of unlimited matching funds. That would induce states to be better stewards of their health care budgets, since state lawmakers would no longer feel they are getting "free" money from federal taxpayers.

7. Innovations in Health Care Services

Recommendation

Policymakers should avoid heavy-handed regulations that block innovation in the delivery of health care services.

Background

Although over 85% of health care in the United States is paid for by a third party, usually an insurance company or a government agency, a growing number of free-market health care models are becoming common in Washington and across the country. These alternative ways of delivering health care services allow the patient to make all the key decisions in how to access care: where to go, when to go, whom to see, how to pay and how much to pay.

These alternatives are thriving outside the financing and regulatory structure of government, and largely beyond the notice of state legislators. In fact, public officials, even those working in health care regulation, are often among the last to know how the health care marketplace is changing.

At the same time, patients seeking alternatives in health care delivery have the full protection of all the consumer laws, professional licensing requirements, quality-of-service standards and truth-in-advertising rules that apply to any legitimate business activity in the state.

Following is a short description of the innovations and patient-centered conveniences emerging in the private health services market.

Policy Analysis

Concierge Medicine

Concierge medicine is defined as paying a fixed amount of money per month to have 24-hour access to a dedicated primary care physician. Same-day appointments, email access and more time with the doctor are standard services. The vast majority of concierge patients also

have affordable, high-deductible insurance to cover hospitalizations and major medical expenses.

This model is now being applied across a wide range of socioeconomic levels. The movement started with the very wealthy, but today many concierge practices are very affordable. A clinic in Seattle charges adults in their 40s only $768 a year, or just $64 a month.[34] Some charge as little as $35 per month.

Doctors are able to build successful practices because of the volume of patients. The low cost and 24-hour access make it much easier for doctors to practice preventive medicine, and patients with long-term health conditions are more likely to keep their illness from getting worse, thus saving money in the long run.

Convenient Care Clinics

A convenient care clinic is a small health care facility located in a common shopping area, like a mall or large retail store. They are open seven days a week, take walk-in visits and offer affordable services. They are generally staffed by qualified nurse practitioners under the supervision of a doctor. They provide simple medical procedures, testing, immunizations, physicals and preventive health screenings.[35]

Unlike traditional doctor offices, convenient care clinics openly post their prices and accept payment by cash, credit card or insurance. Convenient care members report a 98% patient satisfaction rate.[36]

Large retailers such as Walmart are opening in-store clinics to treat customers with routine medical problems. From a patient standpoint, the convenient location and the reduced cost are major attractions.

There are more than 800 convenient care clinics nationwide, and that number is expected to grow in the future.[37]

Use of the Internet

The internet offers many sites to meet the growing demand for reliable, high-quality health care-related data. People are using the internet to research their own medical conditions, compare results

and outcomes for various procedures and providers, and make cost comparisons before making important care decisions.

The internet is one of the most promising tools for informing people about their own health and options for treatment. For this reason it is important for policymakers not to place regulatory roadblocks or new taxes on this growing and cost-effective source of consumer information.

Value-Based Medicine

Good data now exist that show a definite decrease in health care costs for payers who use a value-based model for their employees. By financially rewarding healthy behavior, like an improved diet, getting more exercise or giving up smoking, these employers have seen a significant drop in their rate of increase in health coverage.

In 2001, Pitney Bowes began a value-based benefits program centered on employees with diabetes and asthma. The company saw its annual costs decrease for both conditions within the first year, and it experienced $4 million in health care savings by the fourth year of the program.[38]

In the late 1990s, executives at Quad Graphics began a program of imposing no copayments on workers who joined a weight- and diabetes-management program or a smoking-cessation program. Total cost for participants ranged from 17 to 21% below previous estimates for each year of the program.[39]

Conclusion

Allowed to function on its own, the free market has the ability to develop creative solutions to the ongoing problems of funding and access in health care that would not work in a rigid government-program setting. Policymakers should encourage more of these activities, letting private innovators in the market explore what works and what doesn't, and then pass the benefits on to health care consumers.

In particular, state lawmakers and the insurance commissioner should not place a stifling regulatory burden on these innovative and

practical ideas, as they have done to hospitals and clinics with the costly and time-consuming Certificate of Need process.

Recommendation

Policymakers should avoid heavy-handed regulations that block innovation in the delivery of health care services. Over-regulation by the state would prevent doctors and clinics from developing new ways to build relationships with patients. It would also prevent medical professionals from using new technology, such as electronic medical records, or talking to patients through email, to improve the way they practice medicine.

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